

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048153

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6765

FILED DEC 27 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 79 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 7 5630 VIRGINIA		d. STREET ADDRESS (If outside, give location) 5630 VIRGINIA	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) RALPH STEWART MARTIN			4. DATE OF DEATH DEC 12 1963		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1883	9. AGE (last birthday) 80	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL INSPECTOR			10b. KIND OF BUSINESS OR INDUSTRY K.C. STAR		
11. BIRTHPLACE (City and state or country) DENVER COLORADO			12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME ALEXANDER J. MARTIN			13b. MOTHER'S MAIDEN NAME LELIHA MONMACK		
14. NAME OF HUSBAND OR WIFE ALFRE MARTIN			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT ALFRE MARTIN, 5630 VIRGINIA AVE		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Circulatory Failure DUE TO (b) Right Heart Failure (Cor. Pulmonale) DUE TO (c) Emphysema - Chronic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension - sequelae of the same		PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION KANSAS CITY		
21. I attended the deceased from 9-6-1963 to 12-9-1963 and last saw him alive on 12-9-1963 Death occurred at 3 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 12-12-1963	
22a. SIGNATURE Jackson Asher M.D.	22b. ADDRESS 1220 Professional Bldg Kansas City - Mo		22c. DATE SIGNED 12-12-1963
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 14, 1963	23c. NAME OF CEMETERY OR CREMATORY MOUNT MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS, KANSAS CITY, MO		25. DATE RECD. BY LOCAL REG. 12-13-63	26. REGISTRAR'S SIGNATURE Beaure Smith

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Medical Certification

Gram Asher

RECEIVED-1941

RECEIVED-1941

Harold C. Cullen
Prof. Bldg.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold C. Cullen

Licensed Embalmer No. 4998

P. O. Address J. R. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.